KANSAS DEPARTMENT FOR AGING & DISABILITY SERVICES
Supervised Professional Experience Documentation

The **applicant** shall complete Parts 1 and 2 and signs the back of this form.
The **supervisor** shall complete Parts 3 and 4 of this form within 30 days of completion of the supervised postgraduate professional experience.

Part 1 APPLICANT INFORMATION

Applicant Name_____
Last First MI Other last name used

Address_____
Street PO Box City State Zip

Telephone: Work (_____)_____ Home (_____)_____

Temporary License Number_____Issue Date_____ Expiration Date_____

Part 2 EMPLOYMENT INFORMATION

Name of Employer_____

Employing Agency_____

Address_____
Street PO Box City State Zip

Business Telephone (_____)_____

Part 3 SUPERVISOR INFORMATION

Name of Supervisor_____

Business Address_____
Agency/Business Street/PO Box City State Zip

Business Telephone (_____)_____

Kansas License Number _____ Expiration Date_____

Part 4 SUPERVISOR'S REPORT

Supervision Period Began On _____ Supervision Period Ended On_____

How many hours per week did the applicant work? _____ 35 or more
_____ 25-34
_____ 20-24
_____ 15-19

Percent of work week applicant spent in direct client contact, i.e., assessment, diagnosis, evaluation, screening, habilitation, or rehabilitation of persons with speech, language or hearing handicaps:_____%

Complete Chart A indicating the number of onsite observation hours and other monitoring activities completed during each month (chronologically). Refer to Chart B for the required number of months and complete Chart A only for the months that this report covers.

(Over)

Chart A: Supervision

Month of Supervision	Number of Onsite Hours	Number of Hours of Other Monitoring Activities
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
Total Hours	**Total Number of Activities**	

Chart B: Time Requirements

Required Number of Months When Working the Following Number of Hours Each Week
15-19 hours/week must work 18 months 20-24 hours/week must work 15 months 25-34 hours/week must work 12 months 35+ hours/week must work 9 months

Based upon your monitoring and evaluation of the applicant, do you find the applicant has satisfactorily completed the supervised postgraduate experience? _____ Yes _____ No

If no, please explain:_____

I have discussed this report with the applicant and attest that the information as reported is correct.

_____

Signature of Supervisor **Date**

Applicant: I have read and discussed this report with my supervisor and:

____ I concur with the supervisor's report or

____ I do not concur with the supervisor's report.

_____

Signature of Applicant **Date**

Mail completed form to:
Health Occupations Credentialing – 612 S Kansas Ave - Topeka KS 66603